Annual Model of Care Training

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Overview

- Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Special Needs Plans (SNPs) to have a Model of Care (MOC)
- Information about the program must be available for submission to CMS or for review during monitoring visits
- CMS requires all SNPs to conduct initial and annual training that reviews the major elements of the MOC for providers
- Purpose of this training is to comply with the statutory requirement of CMS that all SNPs provide a general understanding of the requirements of the MOC

What is PruittHealth Premier?

- We offer 2 types of Medicare Advantage (MA) coordinated care plans:
  - I-SNP (Institutional Special Needs Plan)
  - D-SNP (Dual Special Needs Plan)

First, we will review the I-SNP

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Institutional Special Needs Plans (I-SNPs)

- I-SNPs restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a:
  - Skilled nursing facility (SNF)
  - LTC nursing facility (NF)
  - Intermediate care facility for the mentally retarded (ICF/MR)
  - Inpatient psychiatric facility

Dual Special Needs Plans (D-SNPs)

- The D-SNP restricts enrollment to eligible individuals who have both Medicare and Medicaid and who live in the designated service area, currently Clarke County

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Who Can Join the I-SNP or D-SNP?

I-SNP

- Entitled to Medicare Part A (Hospital Insurance)
- Enrolled in Medicare Part B (Medical Insurance)
- Live in Plan service area
- Do not have End-Stage Renal Disease (ESRD) at enrollment
- Not enrolled in Hospice at time of enrollment
- Must reside, or be expected to reside, in a participating I-SNP nursing facility for greater than 90 days at time of enrollment

D-SNP

- Eligible for Medicare Advantage;
- Entitled to Medicaid assistance under Georgia's State plan; as reflected in the agreement between DCH and the Plan; and,
- Reside in the D-SNP service area (Clarke County)
- Cannot at the time of enrollment be diagnosed with ESRD
- Cannot at the time of enrollment be enrolled with Hospice

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What is a Model of Care (MOC)?

- Both I-SNP and D-SNP MOC are PHP's detailed, written commitments to CMS on how we will provide care to enrolled members:

How We Care For Our Members

- MOC is designed to:
  - Reduce non-essential hospital admissions when care can safely be provided in the nursing facility
  - Maintain the residents/patients at an optimal level of function
  - Reduce avoidable admissions

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Elements of the MOC

- MOC 1: Description of the Population
- MOC 2: Care Coordination
  - Staffing
  - The ICP
  - The ICT
  - Care Transitions Process
- MOC 3: Provider Network
  - Clinical Practice Guidelines
- MOC 4: MOC Quality Measurement & Performance Improvement

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MOC 1: I-SNP PHP Target Population

Institutionalized Medicare beneficiary who resides or is expected to reside in a PHP contracted skilled nursing facility for 90 days or longer

- Institutionalized in a LTC facility
- Frail / vulnerable
- More likely to be Female
- Average age is 79 years old
- Typically widowed or single
- Primarily Caucasian
- English-speaking
- Has no identified primary care physician (PCP)
- Often unable to make care decisions and participate in their own care
- May be Confined to a bed or wheelchair
- Has multiple co-morbid chronic conditions (e.g. high blood pressure, heart disease, depression, diabetes, COPD)
- Likely prescribed one or more high-risk medications per month
- Needs help with 5 or more activities of daily living (ADLs) including bed, mobility, dressing, eating and toileting
- High likelihood of reporting daily pain
- Has moderate to severe cognitive impairment
- Overall low health literacy
- Has socioeconomic issues creating barriers to care
- Lacks consistent, engaged caregiver / family support

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MOC 1: D-SNP PHP Target Population

Plan intends to be an All-Dual D-SNP, enrolling all interested duals who live in the plan service area

- Frail/vulnerable
- More likely to be female
- Average age of 79
- Typically widowed or single
- Primarily Caucasian
- English-speaking
- Often unable to make care decisions and participate in their own care
- May be confined to a bed or wheelchair
- Has multiple co-morbid chronic conditions – high blood pressure, heart disease, depression, diabetes, COPD
- Likely prescribed one or more high-risk medications per month
- Often needs help with activities of daily living (ADLs) including bed, mobility, dressing, eating and toileting
- High likelihood of reporting daily pain
- Has moderate to severe cognitive impairment
- Overall low health literacy
- Has socioeconomic issues creating barriers to care
- Lacks consistent, engaged caregiver / family support

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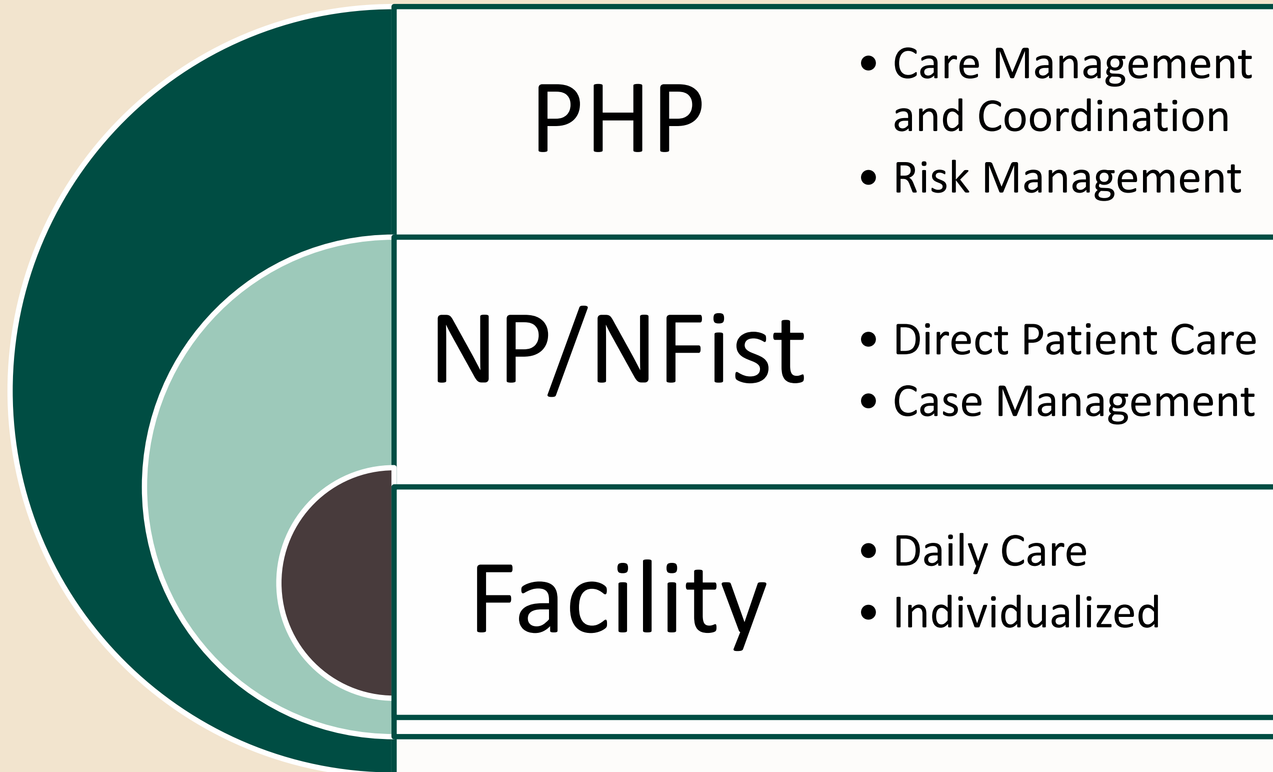
MOC 2: Staffing for I-SNP



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MOC 2: Staffing for D-SNP

Plan Medical Director/PCP

- RN collaboration
- Clinical oversight
- Clinical protocols and guidelines
- PCP will provide direct patient care

Plan Case Manager(RN)

- Care coordination/care planning
- Medication Management
- Care transitions
- Risk stratification
- Patient Education

Medicaid Case Manager

- Home and Community Services oversight
- Case Management
- Care Coordination
- Medicaid service usage monitoring

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PHP Staffing Model

- All members required to choose a primary care physician
  - Onsite primary care services
- PCP/NFist-driven care model
  - For our I-SNP we have dedicated medical providers physically located at the contracted nursing facilities to enhance and provide bedside care management and coordination
- Supported by Nurse Practitioners (NP)
  - On-site primary care support
  - NP has access to the member's facility record, and along with initial risk assessment tools, MDS information and a full history and physical
- Our Case Managers (RNs for D-SNP, NP for I-SNP)
  - Primary point of contact for comprehensive assessments, ICP, ICT, member care transitions
  - Centralized point of contact for members and families/caregivers
- Certain diagnostic tests require a PCP/NFist referral or authorization

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MOC 2: Health Risk Assessment Tool (HRAT)

- All I-SNP and D-SNP members receive a comprehensive history and physical exam and care plan within 90 days of enrollment
- NPs and RN Case Managers utilize a risk assessment tool that rates each member’s medical condition:
  - Low risk: 0-1100
  - Moderate risk: 1100-2000
  - High risk: > 2000
- Risk score dictates the NP’s and Case Manager’s visit schedule
- Risk score framework used at each visit and tracked over time via encounter data

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MOC 2: Individualized Care Plan (ICP)

- Member-centric
  - The member or representative is encouraged to be part of this development and voice preferences for clinical and social interventions
- Includes goals and measures
- ICT agrees and approves
- Shared with the member, as well as the PCP/NFist, NP and ICT members
- Maintained electronically in Align360
- Responses trigger electronic referrals for clinical intervention to the appropriate care teams
  - Monthly inpatient admissions data, claims analysis, and other data triggers are used to revise ICP as necessary
- Evaluated and updated on a quarterly basis or when a significant change in condition or status is identified

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MOC 2: Interdisciplinary Care Team (ICT)

- Developed to ensure effective coordination of care
- Composition varies and is dependent on each members' unique circumstances, risk-level, and individual needs and preferences
- Includes member and representative(s)
- NP for I-SNP and RN Case Manger for D-SNP lead the ICT
- Regular communications
- Continuous monitoring
- Meets quarterly, at a minimum, to review member goals

MOC 2: Care Transitions Process in I-SNP

- PHP NP, PCP/NFist and member's family/caregiver notified of every acute care transition
- Prior to member's transition, SNF completes a checklist/packet that includes:
  - member's comprehensive history and physical notes
  - most recent comprehensive or episodic note
  - consult notes
  - medication list
  - advanced directives
- NP is responsible for coordinating the care transition process
  - POC for communication with the member, their caregiver/family, the doctors, and nursing staff
- Upon return to the SNF, the NP must see the member within 48 hours
  - Comprehensive assessment conducted; discharge summary reviewed and signed; medication reconciliation performed
- NP updates the ICT on the member's status and transition plan no later than 72 hours after the transition event

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MOC 2: Care Transitions Process in D-SNP

For Planned Care Transitions

- The Plan Case Manager will follow up telephonically with the Member prior to the transition to ensure that the Member understands that the Plan Case Manager will be responsible for their care transition and will coordinate their care throughout the stay, at discharge, and post-discharge.

During a Care Transition

- The Plan Case Manager, in collaboration with the PCP, will be the primary point of contact responsible for coordinating the care transition process; ensuring transition of care protocols are followed; and communicating with the Member, their caregiver/family, the ICT, and community based care providers or nursing facility staff during the care transition

Upon Return

- Upon return to the care setting, the CM will make contact with the member within 48 hours to review the discharge summary and medication changes. Within one week the CM will complete
  - Comprehensive assessment; discharge summary reviewed; medication reconciliation performed, review and update of ICP
- CM updates the ICT on the member's status and transition plan no later than 72 hours after the reassessment completion and ICP is updated

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MOC 3: Provider Network

- PHP provides network of providers, specialists, and facilities with specialized expertise pertinent to the care and treatment of its members
- Evaluates provider adequacy with sufficient number of professionals to provide services directly on the premises of the long term care facility such as:
  - Board Certified specialists - Geriatrics, Cardiology, Neurology, Nephrology, Pulmonology, Endocrinology, Orthopedics, Behavioral Health
  - Clinicians - Nurse Practitioners, Physical Therapists, Occupational Therapists, Respiratory Therapists
  - Inpatient facilities - Acute Hospitals and Rehabilitation and Psychiatric

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MOC 3: Clinical Practice Guideline Compliance

- Clinical Guidelines Committee evaluates and adopts clinical practice guidelines applicable to the needs of PHP's membership
- Annually, PHP will review compliance with selected clinical practice guidelines through data analysis
- When guidelines are not satisfactorily adhered to by individual network providers, PHP will intervene with the provider
- When a systemic problem is identified, PHP will undertake broader educational efforts with the network and then evaluate through additional data analysis

Pharmacy & Therapeutics Committee

- Pharmacy and Therapeutics (P&T) Committee provides guidance on formulary development, maintenance and opportunities for enhancing member experience with the Plan
- Utilize tools/techniques to evaluate use of evidence based clinical practice guidelines
- Annual medical record review for high volume PCPs and specialists with a substantiated quality-of-care concern in the past year
- Pharmacy data to identify potential care gaps or potential adverse events and compliance issues
  - Identify real and potential gaps in care and generates notice to physician and member while sending quarterly reports to the Plan for review
  - NPs for the I-SNP and CM for D-SNP receive monthly reports that identify gaps or opportunities for compliance

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MOC 4: Quality Improvement Plan

- Continuous improvement and monitoring of medical care, patient safety, behavioral health services, and the delivery of services
- All data analysis and standard reporting is used in the Annual Quality Improvement work plan
  - Presented to the Board of Directors for their review and approval
- Elements reflecting Plan performance are shared across the Plan and with key Providers
- PHP educates its network and membership with updates regarding performance measures and/or changes in the MOC
- High-volume physicians receive reports on individual performance against expectations and benchmarks

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MOC Compliance

- Who is Responsible for Compliance with the MOC?

Everyone!

- Compliance with CMS requirements and the ethical administration of the PHP I-SNP and D-SNP MOC is an enterprise-wide, shared responsibility

Post Test

- **Please use the attached presentation to answer the questions below:**
- PruittHealth Premier is a Medicare Advantage Plan: True or False
- Medicare Advantage Plans do not cover hospital services: True or False
- Members are eligible for an I-SNP if they have or are expected to reside in a Long term Care facility for how many days? ________
- All Members receive a comprehensive assessment utilizing which tool within Align360? ______________________
- Certain diagnostic tests require a PCP/NFist referral or authorization True or False
- How often will PHP will review compliance with selected clinical practice guidelines through data analysis?_____________________
- The acronym ICT stands for _____________________________________
- The Plan Individualized Care Plan is maintained electronically in _____________________
- Who is responsible for compliance with the Model of Care?_________________________

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